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IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL XTORY [SUMMARY]:
X is X with a date of injury X. X stated X was on X, causing X to X. X stated X. X stated X was X and went to X. X was diagnosed with X. On X, X presented to X, MD for X follow-up evaluation. X was status X. X stated X was doing X. X continued to X. X described X. X was doing X for X but was unable to access X. X was X for X. The X was described as X. The X with X. X ongoing problems included X. Examination showed X. There was X. Single X. There was X. There was X. An MR X MRI, which was likely reflected a X. There was X. Also, there was X. Treatment to date consisted of X. Per a Physician Advisor Report by X, MD dated X, the request for a X. It was determined that X was X. X had X. While the X. Additionally, there

was no specific support in the ongoing evidence-based literature for X. Considering the X. The use X. Based on the discussion above, the requested X. Per an undated Physician Advisor Report by X, MD the request was denied. X: "In the case, the X. X contrast signal at the X MRI. TX likely reflects a X MRI. X of X. No evidence of recurrence. X. No X. Increased X. On X, the claimant had a X, MD via Zoom. The claimant reported having X. The claimant was X. X reported that X. X has not returned to work. X symptoms also included X. The exam revealed X. There was X. There was X. The claimant was diagnosed with X. X treatment plan included X. The request for the X was previously denied since there was no indication of X. No additional information has been provided for review. Therefore, the request for X. The X review results in the following determination regarding the treatment being requested: Non-Certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for X. X had X. While the ongoing symptoms were appreciated, there were no indications of X. Additionally, there was no specific support in the ongoing evidence-based literature for X. Considering the absence of clinical indications of X were not medically appropriate. The use of X was also not medically necessary as its necessity was entirely contingent on the necessity of the X it accompanied. Based on the discussion above, the requested X. Per an undated Physician Advisor Report by X, MD the request was denied. X: "In X case, the MRA of the X. X contrast X MRI. TX likely reflects a X today's MRI. X. No evidence of X. No X. Increased X. On X, the claimant had a X MD via Zoom. The claimant reported having X. The claimant was treating with X. X reported that X. X symptoms also X. The exam revealed X. There was X. There was X. The claimant was diagnosed with X. X treatment plan included X. The request for the X was previously denied since there was no X. No additional information has been provided for review. Therefore, the request for X is not medically necessary at X time. TX review results in the following determination regarding the treatment being requested: Non-Certified."

There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of support within the current evidence-based guidelines to utilize the requested procedure for

treatment of X patient's clinical presentation. Given that the requested X is not medically necessary, likewise the request for X is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL